undergone tracheotomy at the age of 30, had died aged 80, and had worn the tube during the intervening time. Despite the *a priori* physiological arguments as to the importance of warming inspired air in the nasal passages, he knew of people who, while wearing their tracheotomy tube, played tennis, begat children, and did all the other things the ordinary citizen accomplished, except swim! Moreover, they did not seem more subject to bronchitis than were other people. The malignancy in Mr. Howarth's case was of a low form, and he (the speaker) thought that an operation might be performed, which, as regarded severity, would lie somewhere between laryngo-fissure and complete laryngectomy.

Mr. C. A. SCOTT RIDOUT said that he had shown at a previous meeting a patient with a similar condition. This patient had progressed well and was quite cheerful, having had no trouble at all, though since the operation he had suffered from an acute attack of appendicitis. He had never had a cold in the head since the throat operation.

Mr. LIONEL COLLEDGE said that in the first of these specimens the epiglottis had been left; in the second it had been removed with the larynx. On close examination the growth was seen to approach closely the cut edge of the epiglottis. It was better, when removing the whole larynx, to take away the epiglottis at the same time. In some of his own cases, on examining the patient with the mirror, the epiglottis had appeared to be free, but afterwards, in the specimen, it was seen to be deeply infiltrated. With regard to drainage, he had not found gauze drains efficient. He used rubber tubes instead, and as soon as there was much discharge he syringed the tubes through with eusol; a simple rubber tube having lateral holes was the best form of drain.

Sir JAMES DUNDAS-GRANT said that in a case in which he had seen Mr. Lionel Colledge operate, the existing tracheotomy wound was adherent to the surface of the neck, and Mr. Colledge had cut through the trachea above it, bringing the skin together behind the cut surface of the trachea, so that he was then able to plug it until union was established and so to protect the lungs from infection—the patient breathing through the tracheotomy tube. Might not this safeguard be more frequently adopted?

Mr. LIONEL COLLEDGE (in reply to Sir James Dundas-Grant) said that a preliminary tracheotomy allowed the cut end of the trachea to be packed so that the trachea was completely shut off. But in three cases in which there had been preliminary tracheotomies there had been recurrence in the tracheotomy wound, and he wondered whether making an additional wound there before doing the main operation did not expose the patient to an additional risk of recurrence.

Dysphagia for Three Months due to Foreign Body in the Œsophagus.

By C. GILL-CAREY, F.R.C.S.Ed.

History.—Patient, a woman of 32, complained of inability to swallow solid food for three months. Could not remember having swallowed a foreign body. Had lost 2 stone in weight.

Examination.—No abnormality in larynx; no excess mucus in the pyriform fossa.

X-ray examination by Dr. Graham Hodgson, who reported an abnormal opacity in the œsophagus between the sixth and seventh cervical vertebræ.

Œsophagoscopy.—Piece of glass, a portion of which is shown, removed from the œsophagus 25 cm. from incisor teeth. No ulceration of the œsophagus was present.

Complete recovery after removal of the foreign body.

Dr. ANDREW WYLIE (President) said that he had seen the patient in this case, and she had complained very little. Mr. Gill-Carey had removed the foreign body in a very skilful manner. It was uncertain at the time of the operation whether a foreign body was present.

Lymphosarcoma of the Tonsil and Tongue with Glandular Involvement.

By NORMAN PATTERSON, F.R.C.S.

PATIENT, aged 64, female.

History.—Eight years ago the patient noticed swellings on the left side of the neck. Later on she was treated at the London Hospital by X-rays, and the enlargement of